Supreme Court, U.S.
FILED
JUN 10 2005
OFFICE OF THE CLERK

(19)

No. 04-623

IN THE SUPREME COURT OF THE UNITED STATES

ALBERTO B. GONZALES, ATTORNEY GENERAL, ET AL.,
PETITIONERS
v.
STATE OF OREGON, et al.
ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF *AMICI CURIAE* HEALTHLAW PROFESSORS IN SUPPORT OF RESPONDENTS FOR AFFIRMANCE OF THE COURT AND OPINION BELOW

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Preliminary Statement

This Brief of Amicus Curiae Healthlaw Professors is submitted in support of the Respondent State of Oregon and with the consent of all the parties. As in the Court below, Amici have limited their Brief to the practice, procedures and success of physicians and patients under the Oregon Death With Dignity Act. The facts analyzed in this Brief bear directly on Attorney General Gonzales' arguments in his Brief that assisting death is not "treatment in the public interest" with a "legitimate medical purpose, in the usual course of medicine." See Petitioner's Brief, p. 11-24.

The Amici Curiae submitting this Brief are healthlaw professors at American law schools. Each is listed in the Law and Medicine section of the Directory of American Law Schools, published by the Association of American Law Schools. They have published extensively in the field, including the leading casebooks in Healthlaw and Bioethics, as well as dozens of articles in legal and medical journals. In their teaching, they regularly deal with issues of patient autonomy, physician responsibility and healthcare at the end of life.

This Amicus Brief is filed in the hope it will be of assistance to this Court.

Amici Healthlaw professors note, as well, that they and their families – like most Americans – are aging. They may wish someday to urge their legislatures to adopt statutes like the Oregon Death with Dignity Act.

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ADOPTION BY REFERENCE

Amici hereby adopt Petitioners' Provisions Involved and Statement of Facts.

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[1] No individual or organization party to this action has authored or made any financial or other contribution to this Amici Curiae brief.

INTRODUCTION

The opinion in the trial court is reported as *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077 (D. Or. 2002). Judge Jones there enjoined the Attorney General of the United States from implementing his "directive" declaring that medications to assist suicide do not have a "legitimate medical purpose," and further that prescribing them may mean a physician's federal narcotics registration is "inconsistent with the public interest," under The Controlled Substances Act. 21 U.S.C § 823(f); see also § 824(1)(4).

Judge Jones' opinion was affirmed by the Ninth Circuit Court of Appeals. In an opinion by Judge Tallman, the Court held the Attorney General lacked authority to intrude into Oregon medical practices. While the opinion said the Court took "no position on the merits or morality of physician assisted suicide," *Oregon v. Ashcroft,* 368 F.3d 1118 at 1123 (9th Cir. 2004), the Court necessarily found the practice appropriate for state legislation. *Id.* at 1124. The Court also found the Attorney General was making "medical" judgments beyond his statutory authority, *Id.* at 1126-1128, and carefully noted that the Court was not implying that even the Secretary of Health and Human Services could "determine that physician assisted suicide constitutes an illegitimate medical practice." *Id.* at 1127, note 10. The dissent argued the Attorney General not only had authority to determine whether physician assisted suicide is properly the practice of medicine but, in fact, had

ruled correctly, in relying on the Office of Legal Counsel memorandum finding it is not. *Id.* at 1144-1146.

Thus, whether this Supreme Court accepts the view of the majority or dissent below, it must determine whether physician assisted suicide is properly the practice of medicine. *See, Recent Case*, 118 HARV.L.REV. 1321, 1377-8 (2004). To that end, this Amicus Brief presents research data: First, the Oregon Death with Dignity Act assures that terminally ill Oregonians may make responsible healthcare decisions at the end of life; secondly, systematic reporting and continuing oversight provide ample protection against abuse or imposition, particularly on disabled or depressed patients; and finally, the role of physicians under the Death With Dignity Act guarantees sound and ethical medical practices.

These propositions are central to this case. Attorney General Gonazles would revoke Oregon physicians' right to prescribe medications, based on "findings" that assisting suicide represents a danger to the health of Oregonians. The Attorney General is wrong. He made no such "findings," and there is no such danger. The research and data are to the contrary. Various *Amici* below argued that the Death With Dignity Act poses a risk to the poor, or poorly educated, or the disabled, or to incompetent, terminally ill Oregonians. Like the Attorney General, their arguments are grounded in ideology, not facts. This Brief summarizes the research they ignored.

I. THE OREGON DEATH WITH DIGNITY ACT ASSURES SAFE, RESPONSIBLE HEALTHCARE DECISIONS BY TERMINALLY ILL OREGONIANS

A. The Death With Dignity Act Provides a Structure for Competent Healthcare Choices at the End of Life

The genius of the Oregon Act is simple and straightforward. The Act simply provides that a "capable" adult "suffering from a terminal disease" may make a written request for "medication for the purpose of ending his or her life in a humane and dignified manner." Or. Rev. Stat. § 127.805.

The Act then provides, Or. Rev. Stat. § 127.800 *et. seq.*, that before a patient is qualified to proceed, a

> . . .consulting physician shall examine the patient and his or her relevant medical records and confirm in writing the attending physician's diagnosis that the patient is capable, is acting voluntarily and has made an informed decision." Or. Rev. Stat. § 127.820.

There are thus two fully licensed physicians involved in the process, an "attending" (having primary responsibility for treatment) and a "consulting" ("qualified by specialty or experience to make a professional diagnosis and prognosis"). Or. Rev. Stat. § 127.800(2) and (4).

The two physicians not only confirm the diagnosis and prognosis; they must also confirm the patient is "capable," that is, has the ability "to make and communicate health

care decisions to health care providers" Or. Rev. Stat. § 127.800(3). And the patient must have "voluntarily expressed his or her wish to die," Or. Rev. Stat. § 127.805; that is, it must be preceded by full information received from the attending physicians as to the diagnosis, prognosis, risks, probable results and "feasible alternatives." Or. Rev. Stat. § 127.800(7).

This emphasis on informed decisionmaking assures central constitutional values of autonomy recognized by this Supreme Court in *In Re Cruzan*, 497 U.S. 261 (1990) and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). This is facilitated by the Act providing a form: Request for Medication, to be filled out by the terminally ill patient. The form requires two witnesses, and the diagnoses of two physicians, but the consent only of the patient. Or. Rev. § 127.835. The patient shall indicate whether he or she has informed family or chosen not to do so. Or. Rev. Stat. § 127.897.

The prescribing physician is required, immediately prior to writing the prescriptions, to determine whether the patient has made an "informed decision." Or. Rev. Stat. § 127.815(1)(i), 127.830. The patient must have made two requests – one oral, one written – and repeat the oral request within fifteen days, Or. Rev. Stat. § 127.840, at which time a chance to rescind must be afforded. Or. Rev. Stat. § 127.845. A prescription for life-ending medication(s) may not be issued sooner than fifteen days after initial oral request. Or. Rev. Stat. § 127.850.

A patient may be referred for counseling, Or. Rev. Stat. § 127.815(e), if appropriate, pursuant to Or. Rev. Stat. § 127.825. The counselor must then determine the patient is not suffering from a "psychiatric or psychological disorder or depression causing impaired judgment." As noted later in this Brief, See Part II C., about 20% of requesting patients are referred on suspicion of depression and virtually none receives a life-ending prescription.

In essence then, Oregon law leaves to the competent, well informed, terminally ill patient a choice, but surrounds the patient with safeguards and safety nets. The experience of the past seven years demonstrates the success of this structure.

B. <u>Death with Dignity is Chosen Annually In Oregon By A Sizeable Group of Physicians and Patients.</u>

In Oregon, during the first year of the Death With Dignity Act, 23 people received prescriptions and 15 died after taking them. Their median age was 69. They were similar to "control" patients in most respects (sex, race, education, insurance, concern for finances), except the "case" patients had a greater concern about loss of autonomy and bodily functions. At death, 21% of the case patients and 84% of the controls were completely disabled. Chen, Hedberg et al., *Legalized Physician-Assisted Suicide in Oregon - The First Year's Experience*, 340 NEJM 577 (1999). There was no evidence to support fears that assisted suicide would be forced on patients who were

"poor, uneducated, uninsured or fearful of the financial consequences." *Id.* at 582.

During 1998, the second year of the Death With Dignity Act, 24 patients in Oregon received prescriptions. Sixteen died after ingesting the medication. Sullivan, Hedberg et al, *Legalized Physician-Assisted Suicides in Oregon - The Second Year*, 342 NEJM 598 (2/24/2000). They were similar demographically to those who died in the first year. Some 63% had end stage cancer and 78% were in a hospice program. *Id.* at 599.

Three or more reasons were discussed by 7 of 16 patients: loss of autonomy, an inability to enjoy life's activities, and inadequate control of pain. None mentioned cost of treatment or prolonging life as a concern. 342 NEJM at 600-602. The patients' reasons were confirmed by physicians and family members, although family members reported the patients had additional reasons, including a desire to control circumstances of death and fear of coma and respiration problems:

> Many family members emphasized that the patient wanted to have control over how he or she died . . . Family members expressed profound grief over their loss. However, mixed with this grief was great respect for the patient's choice. One man said about his wife of almost 50 years, "She was my only girl; I didn't want to lose her . . . but she wanted to do this." *Id.* at 603.

During the year 2000, the third year of the Oregon Act, 39 prescriptions were written and of these, 26 died after

taking the medication. The reasons and demographic characteristics remained the same (except that in 2000 more were married), and were identical to the 6981 Oregonians who died of similar diseases. As their educational level increased, so did the likelihood of choosing assisted suicide. Sullivan, Hedberg, et al., *Legalized Physician-Assisted Suicide in Oregon, 1998-2000,* 344 NEJM 605 (2/22/2001). As previously, the diagnosis was cancer in 3/4 of the deaths. The physician was present for half of the deaths and the patient died at home (including hospice) in 90% of the cases. *Id.* at Table 1.

In 2001, 33 physicians in Oregon wrote 44 prescriptions. Death from ingestion came to 19; 14 died of the underlying diseases. The demographic characteristics and motivations remained the same. Twenty patients died at home; physicians were present while nine took the medication. Complications (vomiting) were noted in only one case. Hedberg & Southwick, *Legalized Physician-Assisted Suicide in Oregon, 2001*, 346 NEJM 450 (2/7/2002), Table 1.

The Death with Dignity Act has come to enjoy stable acceptance and support over the past seven years. As the Seventh Annual Report of the Oregon Department of Human Services summarized in March of this year:

> In 2004, 40 physicians wrote a total of 60 prescriptions for lethal doses of medication, the first decrease in the annual total of prescriptions written since PAS became legal in Oregon. In 1998, 24

prescriptions were written, followed by 33 in 1999, 39 in 2000, 44 in 2001, 58 in 2002, 68 in 2003, and 60 in 2004. Thirty-five of the 2004 prescription recipients died after ingesting the medication. Of the 25 recipients who did not ingest the prescribed medication in 2004, 13 died from their illnesses, and 12 were alive on December 31, 2004. In addition, two patients who received prescriptions during 2003 died in 2004, after ingesting their medication, giving a total of 37 PAS deaths in 2004.

Although five fewer patients ingested lethal medication in 2004 compared to 2003, the trend has been upward since legalization. Paralleling the upward trend in the number of deaths are the ratios of PAS deaths to total deaths. In 1998 there were 5.5 PAS deaths per every 10,000 total deaths, followed by 9.2 in 1999, 9.1 in 2000, 7.0 in 2001, 12.2 in 2002. 13.6 in 2003, and an estimated 12/10,000 in 2004 (page 4).

The Oregon Act is thus working fairly and well. There are safeguards to assure this will continue.

C. <u>Patients Choose Assisted Suicide for Thoughtful, Responsible Reasons</u>

A 1999 survey of 4500 Oregon physicians found no instances of imposition or discrimination based on disability, poverty or education. Ganzini, Nelson et al, *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 NEJM 557 (2/24/2000). The authors concluded:

> There is concern that with the legalization of assisted suicide, women, poor persons, and those who are members of ethnic or racial minority groups may request assistance with suicide because of inadequate social support or lack of access to health care. . .More than a third of the patients requested assistance with suicide because they perceived themselves as a burden to others, but only three of these patients received prescriptions for lethal medications, *suggesting that the physicians were reluctant to accede to requests for assistance under these circumstances.* (emphasis supplied).

A survey in 2001 of hospice nurses and social workers revealed important dimensions of the practice of assisted death under the Oregon Act. Ganzini, Harvath et al, *Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance with Suicide*, 347 NEJM 582, 584-5 (8/22/2002):

> According to the hospice nurses, the most important reasons for requesting assistance with suicide, among patients who received prescriptions for lethal medications, were a desire to control the circumstances of death, a desire to die at home, the belief that continuing to live was pointless, and being ready to die (Table 2). *Depression and other psychiatric disorders, lack of social support, and concern about being a financial drain were, according to nurses, relatively unimportant.* (Fig. 1).

* * *

> Hospice social workers reported that the desire to control the circumstances of death, the wish to die at home, loss of independence or fear of such loss, and loss of dignity or fear of such loss were the most important reasons for requesting prescriptions for lethal medications; the median score for all these reasons was 5 on the 1-to-5 scale. *They ranked lack of social support and depression as the least important reasons; the median score for both was 1.* (emphasis supplied)

Perhaps the most significant statistic is that each year, about one-third of qualifying patients choose against taking the prescribed medication, evidencing the care and autonomy reserved to them by the Oregon law and medical practice.

II. CONTINUING OVERSIGHT ASSURES EXTENSIVE PROTECTION FOR TERMINALLY ILL PATIENTS UNDER THE OREGON DEATH WITH DIGNITY ACT

A. Contemporaneous Recordkeeping Guides Patient and Physician At All Times

The Death With Dignity Act requires an ample "paper trail" for documentation that the Act's requirements are observed and that patients' rights are protected. A Request for Medication must be witnessed by two people who attest the patient is "capable, acting voluntarily, and is not being coerced to sign the request." Or. Rev. Stat § 127.810(1); Or. Rev. Stat.§ 127.897. Importantly, the patient's request form recites the elements of the Act (disease, information,

request) and includes information concerning advice to the family, the right to rescind, and the possibility that death may take more than three hours.

Oregon also requires that an extensive medical record be kept be kept on each patient. Or. Rev. Stat. § 127.855. This includes documenting both oral and written requests "for medication to end his or her life in a humane and dignified manner." The medical record must document the attending and the consulting physicians' findings as to prognosis, diagnosis, and the patient's voluntariness, capabilities and informed decision." It must also include the outcome of counseling, the offer of rescission at the time of the second oral request, and "a notation of the medication prescribed." *Id.*

Oregon thus assures patients the safety afforded by both medical and governmental administrative oversight. The latter has thus far generated seven Annual Reports by the Oregon Department of Health. These may be found online at the Department website, www.ohd.hr.state.or.us/chs/pas/year 4/or-index.ht. The Reports also are published in the NEW ENGLAND JOURNAL OF MEDICINE, as indicated earlier in this Brief. Each Report is approximately twenty pages in length and is accompanied by tables, detailing the extent of activity under the Act and the characteristics of the patients who sought and received assistance in dying. The result is that records are not simply filed and ignored; rather, they are

collected, analyzed and the results reported in respected, peer-reviewed medical journals.

The Seventh Annual Report of the Oregon Department of Health summarized the reporting and oversight practices as follows:

> When a prescription for lethal medication is written, the physician must submit to DHS information that documents compliance with the law. We review all physician reports and contact physicians regarding missing or discrepant data. DHS Vital Records files are searched periodically for death certificates that correspond to physician reports. These death certificates allow us to confirm patients' deaths, and provide patient demographic data (e.g. age, place of residence, educational attainment).
>
> In addition, using our authority to conduct special studies of morbidity and mortality, DHS had conducted telephone interviews with prescribing physicians after receipt of the patients' death certificates. Each physician was asked to confirm whether the patient took the lethal medications. If the patient had taken the medications, we asked for information that was not available from previous physician reports or death certificates–including insurance status and enrollment in hospice. We asked why the patient requested a prescription, specifically exploring concerns about the financial impact of the illness, loss of autonomy, decreasing ability to participate in activities that make life enjoyable, being a burden, loss of control of bodily functions, inadequate pain control, and loss of dignity.

We collected information on the time to unconsciousness and death, and asked about any adverse reactions. Because physicians are not legally required to be present when a patient ingests the medication, not all have information about what happened when the patient ingested the medication. If the prescribing physician was not present, we accepted information they had based on discussions with family members, friends or other health professionals who attended the patients' deaths. We also accepted information directly from these individuals. We did not interview or collect any information from patients prior to their death. In lieu of the telephone interview, physicians had the option of printing the questionnaire from our web site . (p. 10).

B. <u>There Is No Evidence Of Imposition On Depressed Or Disabled Patients</u>

The Oregon Death With Dignity Act, Or. Rev. Stat. § 127.800 *et seq*., has a number of protections to assure against abuse and overreaching. For example, it specifically provides that "No person shall qualify ... solely because of age or disability." Or. Rev. Stat. § 127.805. Also, any person who may be "suffering from a psychiatric or psychological disorder or depression causing impaired judgment" must be referred for counseling and cannot receive life-ending medication. Or. Rev. Stat. § 127.825. As noted above, a second opinion is required, and an extensive informed consent process is required as well.

Critics of the Oregon practice argue that it puts at risk vulnerable patients, such as those depressed or disabled.

This is a legitimate concern, but not supported by the facts. The danger that a terminally ill patient may be depressed is substantial; the requirement of a clinical evaluation – as a safeguard – is thus very important. *See* Ganzini and Lee, *Psychiatry and Assisted Suicide in the United States*, 336 NEJM 1824 (6/19/97). The seven Annual Reports are strikingly consistent: among patients receiving life-ending medication, there is little evidence of depression.

A survey of 545 hospice nurses and social workers clearly showed that patients clinically depressed were screened out of assisted death. Ganzini, Harvath et al, 347 NEJM at 582, 586:

> Outside of Oregon, one of the most consistent findings in studies of seriously or terminally ill patients is that depression increases the likelihood of a preference for hastening death. According to a survey of physicians in Oregon, *20 percent of patients who requested a prescription for lethal medication were depressed, though no depressed patients received prescriptions.* Hospice social workers have expertise in evaluating mood disorders in terminally ill patients. In our study, hospice social workers rated depression as *one of the least important of all 21 possible reasons* for requesting assistance with suicide among patients who received prescriptions for lethal medications.
>
> • • • •
>
> Our results suggest that *enrollment in a hospice program may offer additional protection.* Most requests for assistance with suicide that are

> made by patients enrolled in hospice programs are discussed with coworkers, often at interdisciplinary conferences. Many such patients are evaluated by clinical social workers with expertise in end-of-life care.

Ganzini, Harvath, 347 NEJM at 586-7. (emphasis supplied)

As with depression, critics of assisted suicide argue that patients with disabilities may be victimized by statutes like Oregon's. There is no evidence to support that view. The disability advocates are most often concerned with amyotrophic lateral sclerosis (ALS, Lou Gehrig's Disease). ALS patients, at least within six months of death, favor – and are excellent candidates for – assisted death. A study of 100 patients by Ganzini, Johnston et al., *Attitude of Patients*, 338 NEJM 967 (10/1/98) found 55% would consider assisted suicide. In The Netherlands from 1944 to 1999, 35 patients out of 203 with ALS chose euthanasia and 6 chose assisted death. Veldinle, et al, *Euthanasia and Physician-Assisted Suicide Among Patients with Amyotrophic Lateral Sclerosis in the Netherlands*, 346 NEJM 1638 (5/23/2002).

In Oregon, 56% of patients with ALS said they would consider assisted suicide and 44% said they would request a prescription, if legal. Miller, Rosenberg et al, *The Care of the Patient with Amyotrophic Lateral Sclerosis*, 52 Neurology 1311, 1323 (1999). In Oregon 5% of all deaths from ALS were from assisted suicide, compared with 0.4% with cancer. Ganzini, Block, *Physician-Assisted Death – A Last Resort?* 346 NEJM 1663 (5/23/2002). Reasons included "loss of autonomy, control, independence, and the ability to pursue pleasurable activities." *Id.*

The most recent study and report by the Oregon Department of Health noted that the demography of patients using the statute did not support fears of imposition or discrimination. A higher level of education was associated with PAS. Oregonians with a bachelor's degree were 8.3 times as likely to use PAS; The type of terminal illness was a strong predictor of usage – the highest being for ALS, HIV/AIDS and malignant neoplasms. Seventh Annual Report, p. 13 (2005). This suggests a rational process where patients are making thoughtful choices.

Perhaps the most significant protection for the terminally ill patient - disabled or not - comes from family. Caregivers of ALS patients usually agreed (73%) with the patients' view on assisted suicide. Ganzini, Johnston, 338 NEJM at 971. Caretakers objecting did so chiefly on religious grounds. *Id.* The task of caregiver is daunting – some 34% lost income or quit work as a result of caretaking or in order to caretake. For many, personal plans and social lives suffered. *Id.* at 970-971. The authors found the care givers' attitudes toward assisted suicide were not influenced by these factors, or by fatigue or finance or perception of suffering. During 2004, all patients but one died at home; 89% were enrolled in hospice care. Seventh Annual Report, p. 14 (2005).

In sum, the Death with Dignity Act provides a structure and process for safe end of life healthcare. And it does so consistent with the medical profession's ethics.

C. Patients Do Not Suffer Needless Pain, Mishap or Harm under the Oregon Act

Concern has been expressed that the *mechanics* of dying might be hazardous, producing errors or horrific consequences, such as comas. The fear is unfounded. 78% of the people who died from assisted suicide between 1998 and 2001 did so in safe hospice setting. Ganzini, Harvath, 347 NEJM 582 (8/22/2002). In a national survey, the medications commonly used for assisting death have been opioids and barbiturates, with potassium chloride being used for some injections. Meier and Emmons, 338 NEJM at 1196. In an Oregon survey, the drugs specified included barbiturates, narcotics, metabolic poisons, tricyclic antidepressants, alone or in combination with benzodiazepines, alcohol, cardiac medications, as muscle relaxants, all well-understood, commonplace medications.[2] Lee, Nelson et al, 334 NEJM at 313.

According to the most recent Department of Health Report:

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[2] In contrast, the substance (marijuana) banned by Congress in *Gonzales v. Raich*, ____U.S. ____, 2005, W: 132, 1358 (6/6/05) had *no* legal medical use. Here, the federal challenge is not as to the substances, but the medical practices in using them to assist the terminally ill.

> During 1998-2003 secobarbital was the lethal medication prescribed for 89 of the 171 patients (52%). During 2004, all lethal medications prescribed under the provisions of the DWDA were barbiturates. In 2004, 25 patients (68%) used pentobarbital and 12 patients (32%) used secobarbital. Since the DWDA was implemented, 49% of the PAS patients used secobarbital, 50% used pentobarbital and 2% used other medications (three used secobarbital/ amobarbital and one used secobarbital and morphine). Seventh Annual Report, p. 14 (ODOH 2005).

The average time of death was 26 minutes for the 15 people taking medications during the first year of the Oregon Act. No complications were reported. Chen, Hedberg et al, 340 NEJM at 579. During the second year, 27 patients died within 4 hours, the longest required 26 hours (having ingested only 2/3 of a dose). In the third year, the process remained largely the same: 20% to 30% referred for psychiatric evaluation, 30 minutes from ingestion to death, death at home in 90% of cases, with the physician present in 50%, and no complications (other than one instance of vomiting).

The latest State Report stated that:

> During 2004, physicians reported that three patients experienced complications: two patients vomited a small amount of the medication, one of whom died 15 minutes after ingestion and the other 45 minutes after ingestion. A third patient drank one-third of the prescribed medication and vomited, dying 31 hours later.

> Three patients fell into unconsciousness after having consumed one-half of the prescribed medication, with death occurring 30 minutes, 2.5 hours, and 7.5 hours after ingestion. Another patient said the lethal medication had a "bad taste" and quit after consuming 750 mg of pentobarbital; this patient died 12 hours later. One patient who ingested the entire dose of lethal medication died 19.5 hours after taking it.
>
> None of the patients regained consciousness after ingesting the lethal medication nor were emergency medical services called. Seventh Annual Report, p. 15 (2005).

Reports under the Oregon Act reflect far fewer complications than found in The Netherlands, in part – perhaps – because Oregon has benefitted from the Dutch experience and, unlike The Netherlands, does not employ euthanasia. Two studies in the 1990s in The Netherlands, encompassing 535 cases of euthanasia and 114 cases of assisted suicide, found problems of complication and completion. Groenewoud, Van der Heide, et al., *Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in The Netherlands*, 342 NEJM 551 (2/24/2000).

In addition, the Oregon practice is grounded in positive law, clearly authorizing and regulating physician assisted suicide, while protecting the rights of patients. See, most recently, Gorsuch, *The Legalization of Assisted Suicide and the Law of Unintended Consequences,* 2004 Wis. L.

Rev. 1347, 1358-1371; deVries, *A Dutch Perspective: The Limits of Lawful Euthanasia*, 13 Ann Health Law 365 (2004).

III THE OREGON DEATH WITH DIGNITY ACT GUARANTEES SOUND AND ETHICAL PRACTICE OF MEDICINE

A. The Oregon Act Extends Ample Respect For The Role And Ethics Of Physicians

The Oregon Death With Dignity Act requires the concurrence of at least two fully licensed physicians. One must be the attending physician, with primary care responsibilities. The other is "consulting," with enough expertise to make a "diagnosis and prognosis regarding the patient's disease." Or. Rev. Stat. § 127.800(2) and (4). That relationship guarantees two opinions, employing the "second opinion" so commonplace and widely recommended in medicine.

The provisions of the Death With Dignity Act concerning informed decision or consent, Or. Rev. Stat. § 127.815, are also well understood, commonplace predicates of the physician-patient relationship. And the diagnosis of a "terminal disease" is well within the limits of the physicians' practice and specialties, that the patient has "an incurable and irreversible disease that has been medically confirmed and will within reasonable medical judgment, produce death within six months." Or. Rev. Stat. § 127.800(12).

It is certainly true that Oregon's Act is detailed in mandating the elements of care in an end-of-life situation. The physician shall recommend notification of next of kin and arranging for another person to be present for the death event (and not taking the medication in a public place). Or. Rev. Stat. § 127.815(f)-(h), § 127.835. The Act also charges the physician to inform the patient about rescission, see Or. Rev. Stat. § 127.840, 845 to assure it truly is an informed decision, and "to ensure that all appropriate steps are taken . . . prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner." Or. Rev. Stat. § 127.815(h)-(k).

But none of these mandates is intrusive. Moreover, nothing in these requirements overrides or impinges upon the physician's simple, untrammeled right to decline to participate at all. See Or. Rev. Stat. § 127.885(4). Indeed, the provisions of Or. Rev. Stat. § 127.815, simply provide a careful checklist for good practice, which will then assure immunity from liability. Or. Rev. Stat. § 127.885.

In 2004, the average physician-patient relationship involving PAS was twelve weeks. This assured detailed, thoughtful caregiving by the physician involved. Seventh Annual Report, p. 14 (2005).

Importantly, the attending physician need not be directly involved in the death event. He or she may issue the medication directly, or send the prescription to a pharmacist for dispensing.Or. Rev. Stat.§127.815(1)(c)(4).

And the consulting physician, of course, is required only to confirm the diagnosis. Or. Rev. Stat. § 127.820. Thus, there is no requirement under Oregon statute that either a physician directly bring about death or even be present at the time.

B. <u>Practice Under The Oregon Act Fits Within the Accepted Community Standards of Medicine</u>

The argument that assisted death is not "medicine" or consistent with the "ends" of medicine must be tested against the actual practices of physicians and expectations of patients. The 2005 Report (p. 14) found:

> The prescribing physicians of patients who used PAS during 2004 had been in practice a median of 22 years (range 6-36). Their medical specialties included: family medicine (57%), oncology (22%), internal medicine (8%), and other (14%).
>
> Most physicians (70%) who wrote prescriptions for lethal medication during 2004 wrote a single prescription. Of the 40 physicians who wrote prescriptions in 2004, 28 wrote one prescription, nine wrote two prescriptions, one wrote three prescriptions, another wrote four prescriptions, and one wrote seven prescriptions.
>
> During the first three years after the legalization of PAS, physicians were present at the patient's ingestion of lethal medication half or more of the time. During 2004, the prescribing physician was present 16 percent of the time (6 of 37

patients). Among the remaining 31 patients, 25 (81%) ingested the medication in the present of another healthcare provider/volunteer.

During 2004, one case involving three issues was referred to the Oregon Board of Medical Examiners. This case involved failure to submit a physician survey in a timely manner, filing an incomplete Attending Physician's Compliance Form, and witnessing of signatures on a patient request form.

Physicians nationally now regularly receive requests for assistance in dying. *See*, Meier, Emmons et al., *A National Survey of Physician-Assisted Suicide and Euthanasia In the United States,* 338 NEJM 1193 (4/23/98). Ten medical specialties (e.g. cardiology, geriatrics, neurology) were identified as likely to encounter dying patients. Of those responding, 36% said – if legal – they would hasten death by medication, 24% by injection. Nearly 30% had received such requests from patients. And 20% had complied.

Patient requests for assisted death are not rare, even in states where it is illegal, such as Washington State. A survey by Black, Wallace, et al. *Physician-Assisted Suicide and Euthanasia in Washington State,* 275 JAMA 919 (3/27/96) produced 828 responses, with 12% (99) of the physicians reporting a request during the preceding year. Of 156 patients making requests, 38 (24%) received prescriptions and 21 died as a result. Of 58 patients who requested euthanasia, 14 (24%) received parenteral mediation and died. *Id*. The physicians had a variety of specialties, including oncology, family practice and

internal medicine, *Id.* Table 1. In the majority of cases, diagnoses were terminal cancer or AIDS. *Id*. at 921. The Washington State study is especially significant because Washington is often compared to Oregon, but assisted suicide is illegal there, a ban upheld by this Supreme Court in *Washington v. Gluckberg*, 521 U.S. 702 (1997). The fact that assisted death nevertheless persists and is widespread is compelling evidence of the profession's view of itself and its obligations to the public. Black and Wallace attempted to explore this deep-rooted commitment by in-depth interviews with ten physicians. Four "themes" emerged: physicians hesitate to assess nonphysical suffering; a request changed the nature of the relationship; granting a request was part of the obligation of compassionate care; legal constraints inhibit open discussion with colleagues. 275 JAMA at 923.

The views of Oregon physicians as to assisted suicide were ascertained and evaluated in 1995, shortly after passage of the Death With Dignity Act in 1994. *See*, Lee, Nelson et al, *Legalizing Assisted Suicide – View of Physicians in Oregon*, 334 NEJM 310 (2/1/96). Of those responding 81% had cared for at least one terminally ill patient. Importantly, 71% believed such patients have a right to commit suicide, and 66% believe physician-assistance would be ethical. During the preceding year, 21% had been asked for life-ending medication, 7% complied, half of the patients took the medication.

It is important to emphasize that Oregon does not make the physician the agent of death. Most are not even present at the time of death. The choice and act remain with the

patient, consistent with accepted professional principles on autonomy and beneficence.

C. Under Oregon's Death With Dignity Act Physicians Practice Sound, Compassionate Medicine, Including Palliative Care

In a survey in 1999 of 4,000 Oregon physicians, 144 had received a total of 221 requests for life ending medication. 75% of those patients had a life expectancy less than six months; 20% had symptoms of depression; none received a prescription. Importantly, *palliative measures – including pain control and hospice – were undertaken for 68 patients, and nearly half changed their minds.* Ganzini, Nelson et al, *Physicians' Experiences with the Oregon Death With Dignity Act*, 342 NEJM 557 (2/24/2000). Equally significant, *physicians grant only 1 in 6 requests for lethal medication. Id.*

In one study of 355 oncologists (72.6% response rate), 56 (15.8%) reported participating in assisted suicide or euthanasia. Emanuel, Daniels et al., *The Practice of Euthanasia and Physician-Assisted Suicide in the United States*, 280 JAMA 507 (8/12/98). Overall, they adhered to three main safeguards: (1) requiring repeated requests, (2) ensuring the patient was experiencing extreme pain, and (3) consulting with a colleague. Table 2, *Id.* at 510. In all cases, the patients with pain were receiving palliative care. *Id.*, Table 3. Over half of the oncologists found comfort in assisting, but nearly 40% feared prosecution. *Id.* at 510-511. The authors were concerned with lack of consistent adherence to safeguards and inconsistency in categorizing cases and treatment, *Id.* at 511-512, as well as errors in the administration of the medicine. *Id.* at 512. These concerns

are legitimate, and serve to underscore the value of the safeguards provided and required in the Oregon statute.

Palliative care to relieve pain is urged as an alternative to assisted suicide; some critics maintain its absence drives patients toward assisted death. In Oregon, during the first year under the Death with Dignity Act, the evidence was to the contrary. The same proportions of "case" patients and "control" patients had advance directives and were in hospice care. Chen, Hedberg et al, *Legalized Physician-Assisted Suicide in Oregon - The First Year's Experience*, 340 NEJM 577, 582 (2/18/99). Oregon ranks third in the nation for hospice admissions and among the top five in the use of morphine for pain. *Id.*

> Physicians in Oregon have referred an increased number of patients to hospice programs since 1994 and have made efforts to improve their knowledge of palliative care, according to a survey conducted in 1999.

****

Control of pain has received particular attention. Oregon ranks first among the states in use of morphine. Between 1997 and 2000, morphine use increased by about 50 percent in Oregon (Fig. 2). According to the Drug Enforcement Administration, per capita morphine consumption in Oregon was 4820 g per 100,000 people in 2000, as compared with 2770 g. per 100,000 people in the United States as a whole. In Oregon, substantive palliative interventions, such as control of pain or other symptoms, referral to a hospice program, consultation with another

> physician, or a trial of antidepressant medication, led about half of patients who were considering assisted suicide to change their minds.

Steinbrook, *Physician Assisted Suicide in Oregon*, 346 NEJM 460 at 461 (2/7/2002)

The compassionate care afforded in Oregon by assisted suicide involves the families as well as the patients: The survey of hospice social workers and nurses in Oregon reflected the following, concerning attitudes of families:

> Eighty-five percent of hospice nurses reported that all close family members of patients who received a prescription for a lethal mediation knew about it, and 90 percent said that all or most of the family members accepted the patient's decision to pursue assisted suicide. (Table 3). Seventy-seven percent of nurses and social workers reported that they had discussed the patient's request for a prescription with the family. Overall, families of patients who receive prescriptions for lethal medications were more accepting of and prepared for the patient's death, although they were somewhat more likely to be distressed than were the family members of other hospice patients.

Ganzini, Harvath et al, 347 NEJM at 586.

CONCLUSION

The facts are these: In Oregon, competent patients, for competent reasons, when faced with a terminal illness, may wish to choose the time, place and manner of death. Oregon has assured its citizens they may do so, safely and

with dignity. And, in choosing to assist death, physicians are practicing good medicine. This is the well-grounded position of the electorate and citizenry of Oregon, who have twice authorized the Oregon Death with Dignity Act by state-wide referenda.

This medical system has now worked safely and compassionately for seven years, helping hundreds to obtain death with dignity. There is no evidence of discrimination against the poor, the disabled, the ill educated, the depressed. Instead, careful monitoring establishes that Oregon annually dozens of enables capable, thoughtful citizens to face their ends with autonomy and dignity. The physicians who assist their patients are themselves free to practice medicine consistent with their medical and personal ethics, prescribing familiar medications regularly prescribed for routine medical purposes.

This case is thus in sharp contract to *Gonzales v. Raich*, ____ U.S. ____, 2005 WL 1321358 (6/06/05), where the medicinal substance (marijuana) had been declared by Congress to be illegal and of no medicinal value. The patients only argument was that this exceeded Congress' Commerce Clause authority. Here, the physicians and patients are using medications routinely and regularly prescribed for medical purposes. Congress has not banned

them, and the Attorney General has no authority himself to ban sound medical practice using them.

Respectfully Submitted
Amici HealthlLaw Professors

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June 10, 2005

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CERTIFICATE OF SERVICE

I certify that on June 10, 2005, I directed the original and forty copies of the *Amici Curiae* Brief, together with the original consents of all parties to be filed with the Clerk, by overnight courier. I also directed that copies of the *Amici Curiae* Brief be sent by United States Postal Service to the following at the following addresses:

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